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Boyle Lecture 2020

with Christopher C. H. Cook, “Mental Health and the Gospel: Boyle Lecture 2020”; and Fraser Watts, “Mental Health and the Gospel: A Response to Christopher Cook.”

MENTAL HEALTH AND THE GOSPEL: BOYLE LECTURE 2020

by Christopher C. H. Cook 

Abstract. Mental health has become a domain of professional and scientific endeavor, distinguished in the modern mind from spirituality, which is understood as a more subjective, transcendent, and private concern. This sharp separation has been challenged in recent decades by scientific research, which demonstrates the positive benefits of spirituality/religion (S/R) for mental health. Increasing scientific interest in the topic is to be welcomed, but the contribution of theology to the debate has been neglected. It is proposed here that Jesus’ life and teaching are presented in the synoptic Gospels as fundamentally concerned with what we now call mental health. Jesus’ teaching on worry, for example, offers various psychological strategies for dealing with anxiety. Moreover, it presents prayer as an effective and constructive response to worry, involving disciplined attention rather than avoidance. Critical interdisciplinary conversations between science and theology on matters such as worry offer a constructive approach to understanding the human condition in the context of adversity.

Keywords: anxiety; Robert Boyle; Gerasene demoniac; gospel; mental health; religiosity; sermon on the mount; spirituality

In the ongoing dialogue between science and theology, certain topics seem to reoccur with some frequency. Creation, cosmology, quantum physics, evolution, and the emergence of the human soul/spirit are all favorites. Other topics seem to be discussed much less than you might imagine they would be. Among these neglected or avoided subjects of conversation, medicine in general and mental health in particular are especially conspicuous by their absence. This is reflected in the records of the Boyle lectures. Unfortunately, we do not have a comprehensive record, but as

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far as I can see lectures were given for at least 193 of the last 329 years and none of these were on medical topics. One hundred and one different lecturers have delivered these lectures and sermons and yet it would seem that I am the first ever medically qualified lecturer. I cannot imagine that Robert Boyle would have approved of this. The only university degree that he ever acquired was that of Doctor of Medicine, *honoris causa*. One can see in his medical writings the early development of what we might call a scientific basis for thinking about the practice of evidence-based medicine, albeit still very rudimentary. Given the exponential growth in the medical and health sciences since Boyle's day, I think he might be rather pleased that, after all these years, we have finally got around to giving attention to them.

SCIENCE, THEOLOGY, AND MENTAL HEALTH

My topic this evening will be mental health, and I trust that I do not need to explain why this is so important in our day. Depending upon exactly which diagnoses we include, around one-fifth to one-quarter of people worldwide experience a mental health problem at some point in their lives (Steel et al. 2014; Bebbington and McManus 2020). Mental disorders account for one-third of years lived with disability, making them by far the leading cause of disability (Vigo, Thornicroft, and Atun 2016). Moreover, mental health problems challenge our very experience of ourselves as human beings and our relationships with one another and with God. When our mood, our perceptions, our cognitive functioning, or our behavior are distorted by dysfunction of brain or mind we are confronted with the most important questions as to who we are and what it all means. If I hear a voice from heaven telling me that God is pleased with me, am I having a profound religious experience or am I suffering from schizophrenia? If dementia robs me of my ability to remember my own recent history, changes my personality, and prevents me from managing my own affairs, in what sense am I still "me"? If my depression leaves me feeling that God has abandoned me, no amount of reassurance from others may be sufficient to re-engage with the love that I used to feel. We now have at least partial scientific answers to all of these questions, but they are also important theological questions and we have yet to properly connect the dialogue between science and theology in such a way as to find a basis for pastoral and clinical care that is wholeheartedly life giving in spiritual terms.

Before we can make these dialogical connections, we have some bridges to build across an ugly great ditch that separates mental health and theology. Some of you will recognize an implicit quotation here from Gotthold Lessing, and I shall return to that later, but for now let's look at how this ditch operates in mental health practice. Let's suppose that a Christian woman becomes depressed. We will call her Agnes. Agnes' GP, or

perhaps a psychiatrist, may prescribe antidepressants for her, or she may see a clinical psychologist for cognitive-behavioral therapy (CBT). Agnes is withdrawn, lacking in energy, and dispirited in faith. She cannot face going to church, as she would usually, and members of her church do not know how to deal with all of this. Like much of the rest of society, they are ignorant about, and afraid of, mental illness. The social exclusion, and the associated stigma, that Agnes experiences because of this deepens her sense of alienation from God, church, community, family, and herself. Happily, Agnes is receiving medical help, but the general approach to this within her church is similar to what would have happened if she had gone into hospital for surgery. (The only difference is that people are likely to be less sympathetic and she won't be sent any cards or flowers.) The doctors are expected to get her better, and then she will be able to return to her normal life. Meanwhile, folks in church continue with the things that Agnes cannot do because of her illness. They pray, they read the bible, they receive the sacraments, and they talk about their faith. Agnes is excluded from all of this. If she is lucky, she may get to meet with a mental health chaplain in the National Health Service (NHS). He or she may well try to reassure Agnes that God loves her, but the emphasis in recovery will be on continuing with the medical treatments, which, alone, will be expected to get Agnes better. I am caricaturing slightly, but only very slightly. Mental health and Christian salvation are in different compartments of life, separated by a deep and unfathomable chasm. Doctors deal with the former; clergy deal with the latter. The former can be addressed through science; the latter is addressed by theology, spirituality, and biblical studies.

I should note in passing that there is a different version of Agnes' story, within which the insights of medicine and science are eschewed, and faith alone is seen as an effective remedy. This is not an uncommon occurrence worldwide, and is evident in some charismatic and Pentecostal churches in the United Kingdom, but it is really just a different version of the same thing. Mental health and Christian salvation are seen as belonging to different social compartments, one of which—in this case the medical and scientific view of mental health—is seen as having little or no value. There is still no constructive dialogue between theology and science. And, of course, there are yet others, mainly outside the Christian churches, who see no value in theology at all. For them, science has—or one day will have—all the answers. Theology and religion add nothing meaningful or valuable to a critical account of human flourishing. It all adds up to the same thing—a great big ugly ditch, between mental health and Christian faith (and this story is replicated in other religious traditions, although I will not be addressing them today).

SCIENTIFIC AND MEDICAL BRIDGE BUILDING

For their part, medicine and science have begun to realize the need to build a bridge across this chasm. There have been huge advances in recent years, although there is still much professional debate about whether, where, and how to build the bridge. For example, in 2011, the Royal College of Psychiatrists adopted a position statement, *Recommendations for Psychiatrists on Spirituality and Religion* (Cook 2011b),¹ in which the importance of sensitively addressing spiritual and religious needs in clinical practice was affirmed. In 2015, a similar policy document was approved by the World Psychiatric Association (Moreira-Almeida et al. 2016). These developments have come about, at least in part, because of an explosion of scientific research interest, over the last 40 years or more, in the ways in which spirituality and religion impact upon mental health (Koenig 2018). Generally speaking, and notwithstanding some important exceptions, we now know that spirituality and religion seem to be good for human well-being. People who belong to faith communities are less likely to suffer from common mental disorders and tend to have better outcomes following treatment when they do. In at least some cases, spiritual and religious interventions specifically benefit recovery.

There have been some problems and setbacks in building the foundations of this bridge from the scientific side of the ditch. Mental health professionals are more likely to be atheist or agnostic than their patients, leading to a so-called religiosity gap (Cook 2011a), and concerns have been raised about proper ethical and professional boundaries (Cook 2013a). Much of the earlier research was of poor quality and, although methodologically rigorous research is now appearing, and with significantly positive results, the effect size of the impact on mental health variables is often modest. More importantly, spirituality has proven to be an especially difficult variable to measure. Early questionnaires and interview schedules sought to probe the essence of spirituality by way of questions about such things as relationships, meaning, and purpose in life. For example, the Spiritual Wellbeing Scale, devised by Paloutzian and Ellison in 1982, comprises 20 self-report items, each requiring a response on a six-point scale from “strongly disagree” to “strongly agree.” Ten items are addressed to religious wellbeing and ten to existential wellbeing. The existential questions are especially problematic. For example, is the item “I feel that life is a positive experience” really about spiritual wellbeing or is it a measure of a psychological state, or trait? It is spurious to suggest that we have learned anything by discovering that people who respond negatively to such questions are also depressed. The so-called measure of spirituality is simply measuring one aspect of depression.

The same problem arises with virtually all of the questions designed to tap into spirituality. In practice, it is impossible to ask about spirituality in

such a way that the answers will not be shaped by psychological wellbeing. Spiritual and psychological wellbeing are not separate variables. They are confounded with each other. So significant is this problem that Harold Koenig, the leading researcher in this field in the world today, now advocates the abandonment of spirituality as a variable in healthcare research, preferring to focus instead on measures of religiosity (Koenig 2008). Spirituality is a useful thing to talk about in clinical practice, but it has no value for scientific research. Instead, Koenig advocates use of instruments such as the Duke University Religion Index (DUREL) (Koenig and Büssing 2010). The first two questions are:

How often do you attend church or other religious meetings?

How often do you spend time in private religious activities, such as prayer, meditation or Bible study?

At least the answers to these questions are—in theory—objectively measurable. The answers do not depend upon the mental state of the person concerned. The first question addresses organizational religious activity, and the second addresses nonorganizational religious activity. Important though such questions are, we might wonder whether they really get to the heart of the matter? Three further questions address intrinsic (or subjective) religiosity—a concept concerned with beliefs and experiences, but these again look much more vulnerable to psychological influences. Koenig has deliberately excluded all questions addressing extrinsic religiosity, a construct originally distinguished from intrinsic religiosity in a seminal paper by Allport and Ross in 1967. Intrinsic religiosity is concerned with what Allport and Ross called the “master motive” in life. Extrinsic religiosity serves to create a social impression or, as they put it, “[turning] to God, but without turning away from self.” A large body of research has now confirmed that mental health is generally better in people with intrinsic religious orientation. But can we really separate out this master motive in life from the psychological apparatus that enables us to form motivation?

For scientists such as Koenig, the turn to measuring religiosity is completely understandable but, as theologian, I am left wondering. If science can't remove all vestiges of the psychological from its attempts to understand and measure the spiritual, can we—as theologians—do any better? Why do we think that we can separate out the spiritual and the psychological? Perhaps they are completely inseparable? Perhaps each needs the other to fully articulate its own essence? If this is so, then how does it come about that in practice we go about our lives apparently separating them out on a daily basis? And, how is it that theologians and biblical scholars continue to largely neglect the domain of mental health and wellbeing?

In order to probe these questions a little further, I would like to speak about the particular interface that forms the title of my lecture today. What is the connection—if any—between mental health and the Christian gospel? Are they really completely different things, with a deep chasm in between, or are they actually parts of the same landscape?

MENTAL HEALTH

Taking mental health first, it is important to observe that in practice—when we talk about mental health—we often mean mental illness. This negative view of mental health, where it is actually referring to diagnosable mental disorder, is important within mental health services. Psychiatric diagnoses, when they are working properly, provide a useful guide to treatment and prognosis. They help to get people back on the road to recovery. On the other hand, when they become the basis for stigma, social exclusion, and prejudice, thus further adding to the disability imposed by impaired mental functioning, we could well do without them. However, all of this is to focus on the negative. What is mental health in a positive sense? There have been many—often inadequate—attempts to define this, but let us look at the definition offered by the World Health Organization.

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (World Health Organization 2004, 12)

The WHO defines mental health not as the absence of mental disorder but—rather—in terms of capacity to cope with life and to contribute positively in the wider community. The WHO does not mention family—which I feel is a glaring omission. Families usually feel the burden of mental ill health most keenly. I think this definition also overemphasizes work, and it does not mention spirituality or religion at all. However, it does at least define mental health in relationship. Mental wellbeing is experienced in community, not in isolation. It also hints at vocation. Mental health is about “productively and fruitfully” realizing our abilities in relationship with others.

THE GOSPEL

So much for mental health. What about the gospel? I have deliberately juxtaposed these two concepts as conversation partners, because I think that they are representative of the two compartments of life about which I have been talking. Mental health, is the domain of medicine and science. The gospel is the domain of the Church. We do not expect that scientists can tell us anything about the gospel. According to the *Oxford Dictionary of the Christian Church* (Cross and Livingstone 2005, 697), the gospel

is the “central content” of God’s revelation as received by Christians. It is the good news about Jesus of Nazareth. The Greek noun *euangelion* (εὐαγγελίου), and its derivatives, are used more in the New Testament by Paul than by any other writer, but Paul seems to assume that his readers will know what he means by it. He offers us no definition. The word draws on a Hebrew theme of the proclamation of good news from God for the poor, and possibly also on Greco-Roman usage in reference to “joyful tidings” on festival occasions. More importantly, the gospel seems to have been something that early Christians associated with Jesus’ own understanding of his mission. It is a theme that is taken up by Mark in his account of the life, death, and resurrection of Jesus. In different ways, and to a lesser extent it is taken up also by Matthew and Luke.

A focus on certain Pauline writings has sometimes led to an emphasis on the gospel as concerned primarily with sin and atonement. However, this does not do justice to the broader scope of Paul’s thinking. N.T. Wright, one of the leading contemporary authorities on Paul, has suggested that Paul’s gospel, is “a message primarily about Jesus, and about what the one true God has done and is doing through him” (Wright 2009, 156). Paul understood the gospel as being the whole story about Jesus. Similarly, in later usage, Christians began to refer to the written accounts of the life of Jesus as “Gospels.” In a sense, we might say, the gospel *is* Jesus; it is the good news of what Jesus said and did.

CHRISTIAN BRIDGE BUILDING

I hope that in this very brief excursus I have gone some way to convincing you that we may understand the gospel as the very heart of the Christian way. It is firmly on the Christian side of the great ugly ditch, with the science and medicine of mental health equally firmly on the other side. However, as I mentioned earlier, my metaphor here alludes to Gotthold Lessing (1729–81), who first proposed that there was a “broad and ugly ditch” between faith and history (Nisbet 2005, 87). In terms of our concerns today, the gap might be posited as one between outer and objective historical truth and inner and subjective spiritual truth. In biblical scholarship the gap has been seen more as one interposed between the text and faith. The Christian may therefore feel that she stands not so much on the edge of one chasm, but on a narrow promontary between two chasms, with mental health across the other side of one, and the Bible over and across the other. I say this not to cause you to experience mental vertigo during this lecture, but rather in order to draw attention to the religious anxiety that this may cause. In this context, the defenses of biblical literalism on the one hand, and compartmentalization of life on the other, can seem very attractive. However, they come at great cost and I wish to argue that a better integration of our thinking about the science and

theology of mental health has much to offer if we only have the courage to embark upon the bridge building that it requires.

In this context, I would like to do some bridge building, but I am aware that I am not the first to attempt the task. Well before Boyle's time controversial attempts had been made to do something similar. In *The Discoverie of Witchcraft*, published in 1584, Reginald Scot wrote:

As touching those that are said in the Gospell to be possessed of spirits, it seemeth in manie places that it is indifferent, or all one, to saie; He is possessed with a divell; or, He is lunatike or phrentike: which disease in these daies is said to proceed of melancholie. (Nicholson 1886, 430)

The idea that the Gospel accounts of demon possession refer to what Scot would call melancholie, or we would call mental illness, was controversial then and remains so now, at least in some Christian circles. It is not controversial in the psychiatric literature, where there seems to be a pervasive, largely unquestioned, assumption that what we call mental illness today was understood as demon possession in history (e.g., Forcén and Forcén 2014). In fact, this is quite unconvincing to any clinical psychiatrist who reads the Gospels carefully and should be much more professionally controversial than it is. The only exorcism by Jesus of someone whom a psychiatrist today might recognize as suffering from a mental illness is that of the Gerasene demoniac.² Of the others exorcised by Jesus, one appears to be suffering from epilepsy, another is blind, and yet another mute. In two other cases we are given no information at all that would be supportive of any diagnosis, but there is no evidence of mental illness.

The Gerasene demoniac is interesting, not least because we are told that Jesus restores him to his "right mind." He is usually diagnosed by medical commentators as suffering from a major mental disorder such as schizophrenia or bipolar disorder. Biblical scholars commonly say little or nothing about his mental state, preferring to focus on debates about where the event took place. However, this one case hardly gives strong support to the argument that demon possession then is what we call mental illness now. Nor were people of Jesus' time ignorant of the difference. So controversial was Jesus, in what he did and in what he taught, that there seems to have been a debate about whether he was either mad or demon possessed (e.g., Mark 3:21–22). The two could potentially manifest in similar ways, but they were not understood as being the same thing.

Much more could be said about the Gerasene demoniac, and I have written about this elsewhere (Cook 2020a). In passing, we should note that the healing that Jesus brings restores this man in body, mind, and spirit within his community. He is socially reintegrated and he finds a new vocation in telling others what Jesus has done for him. Any account of this episode that focuses exclusively on the demonic misses the point completely. An historical-critical reading of the text gives us reason to question

any reductive demonology imposed by modern readers. We should not assume that the practices, beliefs, and traditions of some contemporary charismatic and Pentecostal churches are the same as those of Jesus as portrayed in the synoptic Gospels.

For now, I would like to turn to Jesus' teaching. It seems to me that this is where the Christian tendency to compartmentalize becomes greatest. Jesus is revered by all as a great teacher, but usually his teachings are placed in ethical and spiritual pigeon holes. He is rarely lauded as psychologically perceptive, albeit he is seen as compassionate toward the poor and vulnerable in society and critical of those who fail to help them. Jesus is seen as psychologically sensitive and socially active, but not as a "go to" source of insights concerning mental health.

I should perhaps pause in passing to dismiss one potential exception here. There are those who have argued that most of the healings and exorcisms that Jesus performed were of conditions that we would diagnose as psychogenic in origin. This was proposed, for example, by Donald Capps, in a book entitled *Jesus, the Village Psychiatrist* (Capps 2008). According to this view, Jesus was a charismatic healer, and the diagnoses of the people whom he healed were really psychiatric conditions, such as somatoform disorder, not physical ones. I'm not really convinced by this argument but, even if I was, I don't think that this makes Jesus a psychiatrist, nor does it affect what I want to say here about Jesus' teachings.

WORRY AND ANXIETY

As an example, or case study, I'd like to talk about anxiety.³ Anxiety, along with depression, is one of the key symptoms of the common mental disorders that affect around one in five adults worldwide today (Steel et al. 2014). We have no reason to believe that such problems were any less in Jesus' day than they are now. Anxiety, like fear, affects us physically as well as psychologically. For convenience, I'll call the psychological component of anxiety "worry," but the two usually go together. We worry about the things that we care about, our families, our health, our work, our faith. Worry, like physical pain, is helpful. It focusses our attention on things that matter. It stops us from burying our heads in the sand, like the proverbial ostrich. However, it can also get out of hand. When it is excessive it can immobilize us and make life miserable. When it occurs in inappropriate situations, or pervasively, we may have little or no conscious awareness of what the real root of the problem is, and so we cannot respond effectively. This is where psychiatry comes in, and we now have a range of effective treatments for anxiety disorders, among which the currently popular and evidence based options are justified on scientific principles deriving from empirical controlled trials, and the disciplinary frameworks of psychopharmacology and cognitive-behavioral psychology.

Jesus had some important things to say about worry, for example, in the Sermon on the Mount, and there is reason to believe that the tradition of this teaching was known to Paul. For example, in his letter to the Philippians, Paul writes:

Do not worry about anything, but in everything by prayer and supplication with thanksgiving let your requests be made known to God. (Phil. 4:6)⁴

This is not so very different to what Jesus has to say in the Sermon on the Mount:

Therefore I tell you, do not worry about your life, what you will eat or what you will drink, or about your body, what you will wear. Is not life more than food, and the body more than clothing? (Matt. 6:25)

These texts, or rather a certain kind of misinterpretation of them, have only increased the anxiety of some Christians. It easily seems as though Jesus and Paul are telling us that we shouldn't worry, or that worry is sinful. This has added guilt and shame to the burdens that anxious Christians carry. But none of us can simply decide not to worry; it doesn't work like that. In fact, Paul talks of his "anxiety for all the churches" (2 Cor 11:28) and Jesus is distressed and agitated in Gethsemane concerning his impending fate, so we should not imagine that either of them lived in a perpetual state of emotional calm in the face of life's challenges. Rather, they both had important things to tell us about how we should handle anxiety and worry when they come our way.

In particular, both Jesus and Paul redirect us to prayer as the appropriate coping response. Jesus also engages in an extended reflection on what anxiety tells us about our true priorities.

Therefore do not worry, saying, 'What will we eat?' or 'What will we drink?' or 'What will we wear?' For it is the Gentiles who strive for all these things; and indeed your heavenly Father knows that you need all these things. But strive first for the kingdom of God and his righteousness, and all these things will be given to you as well. (Matt. 6:31–33)

Jesus also challenges us to live in the present, and not to allow our minds to be distracted by what may or may not happen in the future:

So do not worry about tomorrow, for tomorrow will bring worries of its own. Today's trouble is enough for today. (Matt. 6:34)

We might identify here some of the key techniques of CBT for managing anxiety, but Jesus does not confine himself to this model of psychotherapy. In an interesting parable concerning guilt and blame, later in the same sermon in Matthew's Gospel, Jesus says:

Why do you see the speck in your neighbor's eye, but do not notice the log in your own eye? Or how can you say to your neighbor, 'Let me take the speck out of your eye,' while the log is in your own eye? You hypocrite, first take the log out of your own eye, and then you will see clearly to take the speck out of your neighbor's eye. (Matt. 7:3-5)

This passage closely follows after Jesus' teaching on anxiety, and yet the link seems to be all but completely missed by biblical scholars and commentators. The connection is well known to psychodynamic therapists. In the psychoanalytic tradition and its derivative therapies, various psychological defense mechanisms against anxiety are identified, including one called projection. In projection, some aspect of mental content that causes anxiety in the self is mentally relocated—or projected—onto another person so as to reduce the anxiety. Thus, for example, I might be feeling that I have not worked hard enough, that I am a failure, and that I should have achieved more. I feel both anxious and guilty about this, but more at an unconscious level than something that I am consciously aware of. I am seen by others to be constantly complaining that colleagues at work are lazy, or perhaps I place excessive emphasis upon my children's education and put pressure on them to succeed. I see in others the very thing that I am so unhappy with in myself. By projecting this onto someone else—and blaming them—I avoid experiencing my own anxiety. However, this also makes it difficult to resolve. Insight into what is going on, making conscious that which was unconscious, is half the solution.

It seems to me that the parable of the speck and the log describes exactly this kind of psychological dynamic. I have scoured commentaries of Matthew's Gospel in vain, and have yet to find one in which this teaching of Jesus is identified as being concerned with the psychological defense mechanism of projection. The connection has not been missed by psychotherapists. For example, Brown and Pedder (1991), in their introductory textbook on psychotherapy, refer to Jesus as recognizing this. Jesus' teaching on this is even acknowledged in the online Wikipedia article on psychological projection.⁵ Psychotherapists who are not Christians apparently understand this particular text better than most biblical scholars appear to. But perhaps that is just me projecting my failings onto the biblical scholars?!

At the heart of the Sermon on the Mount is Jesus' teaching that we know as the Lord's Prayer. Paul's injunction to the Philippians not to worry is explicitly linked to an injunction to pray. Anxiety is thus located within the tradition of Jesus' teaching as being something that should impel us toward prayer. Prayer is—we might say—the Christian coping mechanism for dealing with anxiety. In fact, when you think about it, prayer is very similar to worry. Worry and prayer are both a giving of attention to the things that concern us. The differences are in the theological perspective, the God directedness of prayer, and the willingness to challenge ourselves

as to whether or not we really worry about the right things. It is actually a small step to turn worry into prayer, and the Lord's Prayer directs our attention to how we might reorientate our priorities in support of this. It directs our attention to the overriding priorities of the coming of God's kingdom, the kingdom that was at the heart of Jesus' teaching ministry. Subsequent Christian tradition has developed countless variations on how to pray about the things that worry us. The Jesus prayer, centering prayer, or the spiritual exercises of St Ignatius, for example, all offer prayerful ways of addressing our anxieties and probing the desires that they reflect within us.

The Sermon on the Mount begins and ends with warnings that appearances can be deceptive. Jesus' opening words are "Blessed are the poor in spirit, for theirs is the kingdom of heaven" (5:3). Much ink has been spilled in attempts to identify exactly whom Jesus is referring to as "poor in spirit." In Luke's Gospel, in the Sermon on the Plain, it is simply the poor who are said to be blessed. It is difficult, however, to avoid the conclusion that poverty of spirit has an inner and emotional reference. We are thus left with the psychological paradox that those who are said to be blessed are the ones who don't feel blessed. The second beatitude refers directly to those who mourn, and the third to those who are meek. Perhaps, then, the anxious may be blessed too? When, later in the sermon, Jesus says that we shouldn't worry about what we eat or drink, is this a reminder of the fourth beatitude? "Blessed are those who hunger and thirst for righteousness...." It is what we are anxious about that matters. The phenomenology of anxiety, in itself, does not tell us who is blessed and who is not. There may well be some very anxious people who are far more spiritually and mentally healthy than others who have no anxieties at all. Spiritual and mental health are highly paradoxical.

Taking this example—of anxiety and worry—we thus find that Jesus did teach about something that we consider to be a central feature of common mental disorders. Mental health is actually one of the key themes of the Sermon on the Mount; it is there as a part of Jesus' teaching on prayer and the kingdom of heaven. Christian prayer is a psychological as well as a spiritual practice. Mental and spiritual wellbeing are inextricably linked. Appearances can be deceptive, and those who look least as though they are flourishing may in fact be those who are spiritually and mentally most healthy.

INTEGRATIVE THERAPIES

Judging from my reading of commentaries on the Sermon on the Mount, most biblical scholars have not properly taken this on board. Nor have many psychiatrists or psychologists. However, a variety of spiritually and religiously integrated forms of psychotherapy now give explicit attention

to the ways in which scriptural and religious teachings may be used to facilitate recovery from mental ill health. They are adapted to different religious traditions and, of course, Christian theology is not imposed upon Muslims or Hindus, or vice versa. As an example, one Christian version of a religiously integrated CBT manual (Ciarrocchi et al. 2014) suggests that the texts that I quoted above, from Matthew 6, might be useful in helping the patient to identify certain kinds of thinking errors in which they hold fears about the future. The manual is adapted from one originally devised by the psychologist Aaron Beck, and reflects his understanding of the cognitive processes that underlie depression and anxiety. The Christian is enabled to reflect on these in therapy as consistent with the teachings of Jesus.

The links between Christian theology and mental health practices are there for those who wish to make them. Mindfulness, a practice of attentive awareness of the present moment, is now seen as a spiritual therapy which has particular benefits for a number of psychiatric disorders, including depression and anxiety (Hofmann et al. 2010, Goldberg et al. 2018). It is usually seen as drawing on Buddhist practice, but actually shares much in common with Christian contemplative prayer, and with Jesus' teaching about today's trouble being enough for today. As a component of Compassion Focused Therapy (Gilbert 2009) it gives expression to Jesus' teaching on loving our neighbors as ourselves. Forgiveness therapy (Enright and Fitzgibbons 2015), now seen to be valuable in a wide range of psychiatric disorders, draws further on one of the key themes of the Lord's Prayer, and has a substantial evidence base to support its efficacy. I could go on—but I hope that by now you get the picture?

I would suggest, therefore, that there is ample evidence (at least in Matthew's Gospel) that Jesus' teaching on the kingdom of God was both psychological and spiritual in nature. Each depends upon the other, but neither can be reduced to the other without losing something important. This should not be surprising to us given scientific research and theological thinking about the nature of the relationship between mind, brain, and spirit. Philip Clayton's Boyle lecture in 2006, for example, addressed this eloquently. It is an astonishing feat of compartmentalization that we have persuaded ourselves collectively that we can talk about spiritual and mental wellbeing in isolation from each other. Our success in doing so has cost us dearly.

BEYOND DISINTEGRATION

On the one hand, we have deprived ourselves of many of the benefits to mental health that the Christian gospel, and the spiritual practices that have emerged from it over the last two millennia, potentially have. Buddhism is now seen as the source of spiritual wisdom on mindfulness and

compassion amongst many mental health professionals, and Christians are seen as having little to offer. I'm not saying that we can't learn anything from the Buddhists, but—as Christians—we have not done well in sharing the resources of our own tradition with others.

On the other hand, we have impoverished the gospel of its power to speak to the integral nature of the human condition as physical, social, psychological, and spiritual. We have divided up the human soul and outsourced our psychological work to science and medicine. This is not how things were in the Gospels. The kingdom of God is presented by Jesus in Matthew's Gospel as a place of human flourishing in body, mind, and spirit. Just as there is "no health without mental health," there is no mental health without spiritual health. Equally, there is no spiritual health without mental health but, before I finish, I want to further challenge our understanding of the fundamental nature of mental health.

If, as I am suggesting, we have lost any sense of the integrated, indivisible, and holistic nature of the vision of human flourishing that the Gospels portray, what should a Christian understanding of mental health look like within the kingdom of God—in terms that reflect, and engage with, our present scientific understandings of the nature of mental health? Given that I have said that mental health will be inseparable from spiritual wellbeing, it should be possible to articulate this in such a way as to avoid compartmentalization. It should be possible to communicate psychological flourishing in spiritual terms, and spiritual flourishing in psychological terms. The challenge will be to do this in such a way as to preserve the authentic and distinctive insights of the Christian gospel without being unnecessarily exclusive. Of course, any such venture always will be exclusive insofar as it will affirm the uniqueness of what Jesus said and did. However, it should be inclusive, as Jesus was, of those who are excluded and on the margins, of those who are "poor in spirit."

I would like to suggest that—from a gospel perspective—mental health is a state of wellbeing in which a person is able to fulfill their vocation within the Kingdom of God. For the purposes of a dialogue between science and theology we might articulate this, in a slightly different way, as "a state of well-being in which a person is able to show attentive awareness of self, others, and a transcendent reality." In no way do I wish to retract my Christian emphasis on the radical way in which this transcendent reality is given unique expression by Jesus, in word and deed, in the Gospel narratives. However, we have to be able to have a dialogue, and I hope that this definition might facilitate that.

Let's conclude by returning to our consideration of Agnes. While she is still in the place of social and emotional exclusion that her depressive disorder has consigned her to, a psychologist—who is not a Christian—teaches her how to engage in the practice of mindfulness. Recognizing that she is a Christian, he refers her to the mental health chaplain, who

makes some recommendations for her for some reading on mindfulness and Christian prayer. Agnes still feels depressed. She is poor in spirit, but she does find that attentive awareness to simple things gradually becomes a place of daily prayer, and that this in turn enables her to reconnect with a faint and fragile sense of the presence of God in her life. Gradually this grows, and along with it her mood improves. Eventually, she is able to return to church, and her friends there welcome her back and tell her that they are glad that she is feeling better. Within this narrative of recovery, a psychologist and a chaplain have both played a significant part, but church is only there at the beginning and the end. It isn't a central part of the story.

Let's compare this with the story of the Gerasene demoniac. This man is alienated from his community by his mental disorder at the beginning of the story, and reintegrated at the end. He has this in common with Agnes. The agent of change, Jesus, is at the heart of the action in Gerasa, and brings about salvation in body, mind, and spirit. This part of the story looks very different. It is the good old NHS that has brought about most of the changes for Agnes, and they have focused primarily on restoration of mind. The mental health professionals haven't completely forgotten the spiritual dimension of things, but neither have they made it a central, nor integrated, concern. Finally, the Gerasene man has a new vocation; he has good news to share of a new awareness of himself, and his community, and Jesus. Agnes has a similar sense of gratitude, but she still finds it difficult to join up the fragments. Where was God in all of this and what does it have to do with her Christian faith? Where were her church friends when she needed them most? How can she talk to them now about her experiences? Does her church know how to have this conversation with her?

Underlying the difficulties that Agnes has with talking about these things in her church, there is a difficulty that clergy, theologians, mental health professionals, and scientists have with pursuing a proper interdisciplinary conversation between science and theology as to the nature of mental and spiritual wellbeing. This is not just an academic debate, it has direct relevance to clinical and pastoral care. We need much more dialogue—at every level.

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NOTES

1. Later updated (see Cook 2013b).
2. Mark 5:1–20, Luke 8:26–39. See also Matthew 8:28–34.

3. See also my further discussion in (Cook In Press), and (Cook 2020b).
4. All biblical quotations are from the New Revised Standard Version.
5. https://en.wikipedia.org/wiki/Psychological_projection.

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